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Two groups of preschool children from the Boston area were selected to participate in a study of marginal emotional disorders, their diagnosis by an interdisciplinary team, and their effect upon a child's functioning in the preschool setting. The two groups of children who attended the diagnostic sessions consisted of 19 lower class Head Start pupils from the inner-city and eight middle class children from a suburb preschool program. The interdisciplinary team included master teachers, child psychiatrists, psychologists, social workers, and a speech-hearing specialist. Graduate students recorded the behavior of the children. The 27 children attended the diagnostic sessions 3 days a week and were observed, by means of one-way mirrors, by the interdisciplinary team. Staff meetings were held after the sessions to discuss what had been observed and what assistance could be rendered to emotionally disturbed children and their teachers. The project raised more questions than it answered, but among its findings were (1) that social class differences in pathology were not striking, (2) that the data gathering process was not extensive enough, (3) that project communication with the lower class community was insufficient, and (4) that the use of an interdisciplinary team did provide a welcome depth to the informational analysis. (WD)

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HEAD START EVALUATION AND RESEARCH CENTER

PRIMARY AND SECONDARY PREVENTION STUDYING CLINICAL PROCESS AND DISTURBANCE WITH PRESCHOOL CHILDREN[1]

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ABSTRACT

During the summer of 1967, a six week experimental clinical survey with a selected small number of preschool children ranging in age from 3 to 6, from two differing social class communities, evolved a methodological procedure that would assist in clarifying the issue of emotional disturbance and potential emotional disturbance in young children. The primary thrust was to set up closely coordinated interdisciplinary teams that could interact with preschool systems and their representatives on a consistent longitudinal basis. Class differences in the system and attitudes of their personnel were more striking than the actual differences between the children. Techniques of testing, observing, coordinating and recording data were established. Full-year projects based on this model have evolved in the inner city Headstart programs.

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PRIMARY AND SECONDARY PREVENTION

STUDYING CLINICAL PROCESS AND DISTURBANCE

WITH PRESCHOOL CHILDREN[1]

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INTRODUCTION

In the summer of 1967, an interdisciplinary team addressed itself to the study of disturbed preschool children, comparing a selected sample of low and middle class communities with a view to finding a broader, more descriminating definition of emotional disturbance between the ages of three and six than is currently found in the literature. A need to study the epidemiology of emotional disturbance, especially the influences of social class, is evident. Not only were diagnostic procedures for existing emotional disturbance considered, but longitudinal development of the child was studied with the hope of predicting disturbance that might lead to school failure. In summary, emotional disturbance and potential emotional disturbance were investigated. No attempt was made to review a large population. The groups studied were a small group of Headstart children from an inner city environment and a comparable group from a middle class suburban pre-primary program. The question was raised as to finding discriminating data necessary for making useful prediction of the child's functioning in the preschool school setting. Data were studied for developing interventions to use within the classroom for the benefit of the child. The communication process of adults dealing with the child was also studied.

In particular, the process of interdisciplinary communication was scrutinized in this clinical survey. Administrators from the University and community agencies worked closely with teachers, aides, psychiatrists, psychologists, social workers, speech specialists, parents and students, sharpening communication and defining and differentiating problems. One aim of the program was to help teachers identify and cope with emotional disturbance in the classroom, to know where and when to seek help and how to coordinate their efforts with families and community efforts.

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The interest, too, was in sensitizing professionals to their own profession. Teachers need to be remotivated to sense a renewal of committment. This holds for psychiatrists, psychologists and social workers. We not only need to hear and understand what other professionals are saying and doing, but we need to be more aware of definiciences in our own professions. We were particularly interested in seeing how training psychiatrists in the school setting could increase their awareness of the total functions of the child, particularly in helping them to recognize the efficacy of certain teacher interventions, groupings and styles. We wanted to see how teachers would respond to the insights of psychiatrists and psychologists in mutually observing the manifest behavior of a child.

Finally, suggestions were to be made to communities to help them develop resources within their own school systems and family services to help disturbed children. The practical problems of effecting change in established systems, such as the schools, are of considerable importance at this time. The question was considered as to how communities can be motivated to change and adapt their systems to the changing demands of the society around them.

In summary, the clinical approaches of this study led to increasing our knowledge of how professionals change in changing settings. Methodologically, participant observations of interdisciplinary groups led to sensitizing professionals which in turn, hopefully, led to benefiting the child in his variable social settings.

THEORETICAL ISSUES

Many comparative studies have been done in recent years on incidence and type of psychopathology in middle and lower class samples (Hollingshead and Redlich, 1958; Dunham, 1964; Harrison, 1965; Burgess, 1964; Luchterhand and Weller, 1965; Miller and Grigg, 1966; Shoemaker, 1965; Swift, 1966). Only a few have looked at the influences of social class on childhood disturbance. (Charry, 1967; Dairs, 1948; Bennet and Gist, 1964, Deutch, 1965; Hernandez, 1963; Hollingshead, 1949; Jensen, 1966; Miller and Swanson,1960; McDermott, Harrison, Schraga and Wilson, 1965; Sears, Maccoby and Levin, 1957). The incidence of emotional disturbance in selected groups of children and the correlates of socioeconomic status with the type of illness within the population needs scrutiny. Since few such studies have been done in children, more should be attempted in the area of diagnosis of emotional disturbance.

We also need to explore the relationship of emotional disturbance to total personality function and childhood development. We need to know more about how the child's initial experiences in school situations effects his emotional development and how existing disturbances can be ameliorated in the school setting. How does the child change and learn to adapt to the demands of the school? What information can specialists in child development, particularly cognitive development and behavior, provide that would help the teacher and the system benefit the child?

A primary difficulty of such a study is in the actual definition of emotional disturbance, as it is necessary to define emotional disturbance operationally. For this study, emotional disturbance was seen as a function of the child showing deviation in relationship to expected school behavior. There seem to be two groups of children that need examination: One is the severely disturbed group where there seems to be no question in the minds of teachers or consulting professionals that the child is in need of immediate and special help, he could not get along without it; and he certainly cannot cope with a class situation without considerable assistance from the outside.

The next group is the middle group of children who show behavior that is identified as disturbing or disturbed in the classroom. Sometimes only the teacher sees aspects of behavior that she finds disturbing; sometimes the consulting observer, whether psychiatrist, psycologist or consulting teacher, finds disturbing behavior. Often both teacher and consultant are aware of deviance in a child. It is this latter group which is of particular interest to us in this project, since a dialogue between teacher and consultant on observed child behavior could result in a richer and clearer definition of pathology. Whether this deviant behavior has a good or bad prognosis for future success in schools would depend a good deal on the type of deviation that was manifest. This is the area that the total team wanted to explore. Was this child presently showing vulnerability and maladaptive approaches in responding to immediate stress situations or was this deviation going to be of much longer duration? Could it be corrected by the child or would external assistance be needed? Was it necessary to discriminate between deviant behavior caused by intrapersonal dynamics versus deviation caused by undue environmental (low social-economic status) stress? Also to be ruled out was the question of deviation due to a deficiency or maladaptation of the central nervous system.

Several goals could be explored. The following hypotheses were generated and continued to generate theoretical and methodological issues as the survey progressed: 1). By bringing children together from two differing social classes into a diagnostic classroom to be observed by an interdisciplinary team, nosology and social class differences could be viewed simultaneously. 2). The manifestations of emotional disturbance, such as the handling of aggression, sex identification and withdrawal, would differ according to class. 3). Preliminary observation in classroom settings by the professional team, followed by three sessions in the diagnostic classroom, provided an opportunity to get at co-variation between developmental versus situational malfunctioning. To study these variables separately seemed futile, since the interaction of the two is constant. 4). Service had to be provided to the community before any community support would be given to the program. 5). The attitude of school officials, from admistrators through teachers, would be more cooperative and sustained in the middle class group than in the lower class group. 6). Enough structure could be imposed on clinical and observational procedures to facilitate inferential processes on the part of clinicians, and cut down on confounding variables. 7). Certain situations would be detrimentally handled by indigenous, nontrained personnel.

CLINICAL PROCESS

Two groups of preschool children were selected in the Boston area, one from the inner city and one from a middle class neighboring suburb with a relatively stable population. The children in the inner city came from several Headstart classes, those in the suburb from a summer public school pre-primary program. The project was instigated and coordinated by the Boston University Head Start Evaluation and Research Center. Representatives from the faculty of the schools of Education and Medicine, as well as students participated in the project. The Headstart group was coordinated by the South End Neighborhood Action Program(SNAP), a delegate agency of Action for Boston Community Development (ABCD), an inner city community action programs financed by the Office of Economic Opportunity. The suburban group was coordinated by the staff of the public school system, including a school adjustment counselor, and by a local community mental health clinic.

The University provided two classrooms with a large observation room with one-way mirrors. A master teacher and an aide ran the diagnostic class for those children selected from the populations for the purposes of generating diagnostic hypotheses. The class was studied from the observation room by two child psychiatrists, one fourth year resident in child psychiatry, two psychologists, three social workers, a speech and hearing specialist and a consulting master teacher. Observing and recording was done by students in the Boston University Psycho-Educational Clinic.

The children in the Headstart programs had been chosen primarily for their financial need and the degree of stress in the family. 120 children were in 8 classes. From these children, 26 were selected for further study, but only 19 actually came into the diagnostic class, 11 males and 18 females. Eight teachers and 8 aides were assisted by 8 neighborhood workers.

Two-hundred and fifty children, in 3 schools with 9 teachers made up the population of the suburban pre-school. These children had to be 5 years old before January 1, 1968. The pre-primary program had been started in this community because the school system did not feel it could finance a kindergarten program, but since twenty to thirty per cent of the children were failing in the first grade, the schools were backing this attempt to assist children in getting ready for school. Two of the schools were old schools in a middle income area. One school was a new school with a more well-to-do population. Nine children were recommended for the diagnostic class, eight came in, four males and four females.

Preliminary meetings were held by the University professional team with social agencies and teachers involved with these various classrooms to clarify plans and procedures. Beginning with the first weeks of operation, and then regularly throughout the summer, observers, either from psychiatry, including the psychiatry resident in training, and/or education observed in the classrooms. The visits were for at least an hour. If the teacher designated any special problem, or if a child caught the clinical appraisal of the observers, the observers returned for added observation. The teachers did not have to wait for the scheduled visits of the observing teams. If a teacher felt a child needed immediate attention she could call the University and request a visit. The teams tried to get out within two days after the request of the teacher; or a later appointment was arranged when the teachers of the University staff could discuss in detail the behavior of the child and arrange details of his coming for a diagnostic session if this seemed necessary. In several cases, the children were discussed but did not come into the diagnostic class. Specific suggestions were made to the teacher on various ways of handling the child in the classroom and this seemed to suffice in helping the child adjust.

If a teacher wanted a child worked up in detail, she filled out a form with the child's name, her name, the school, the date, the comments of the visiting teams on the child, and her specific questions on the behavior of the child. In addition, the visiting teacher consultant on the team tried to take down verbatim the requests and observations of the classroom teacher. These reports were mimeographed and ready for all members of the staff when the child entered the diagnostic class. Also mimeographed for curculation were the team's observations of the classrooms and of specific children.

Scheduling of the children at the diagnostic class was arranged through the appropriate centers. Each child was to come for three days, Tuesday, Wednesday and Thursday. The diagnostic sessions were routinely observed by the team of psychologists, psychiatrists and educators as well as students in the Department of Education in an observation room, with one-way glass and sound apparatus, large enough to accommodate the numbers of people involved.
After each session, the professional teammet to discuss the behavior of the children they had observed. Predictions and suggestions were made about behavior in the classroom and how to get help outside the classroom, particularly for family problems. Groups of three to six children were seen routinely. Children from both social mileius were present simultaneously. The class was operated much like a standard nursery school program in regard to routine and materials. Two rooms were available, with the large observation room inbetween. On the classroom the children first entered, was arranged in sections. One area had toy furniture resembling a kitchen area including running water; another had round tables with chairs around them; another had shelves with toys, puzzles, crayons, etc. A counter served as an area for shaving cream play, clay work and the like. In the classroom across the hall, which the children spent the latter half of their visit each day, was the large motor equipment: slides, tricyles, jungle-gym-house, rocking boat, pyramid stairs, etc. When the children came over to play in this room, individual interviews, whether for psychiatric workup or for speech and hearing evaluation, were done in the classroom so the child did not have to be removed from his familiar milieu and so that the diagnostic team could observe.

Graduate students in training, were specifically assigned to observe and record the behavior of each child, to assist the team at the final evaluation. These recorders were instructed to note relationships with adults and peers, the attitude of the child to authority, the amount of intention and the time spent on tasks, the handedness of the child, the motor coordination, including eyes, hands, small and large muscles, and to give as much verbatim vocabulary and sentence structure as possible. They were also to look for affect, to note frustration tolerance, attention span, reflexive-impulsive set, and recorded any fantasy themes that could be picked up, and the amount of curiosity, risk and exploring the child showed. Each five to ten minute intervals was noted so the sequence of the child's play and duration of his interest was recorded.

Parents were included in the observational process during the first session. They were invited and arrangements made for their coming through their respective agencies. The parents who did come seemed to enjoy watching the children and talking informally to the team. Teachers of the classrooms and administrative staffs of the agencies were also invited to come and observe the diagnostic sessions, whether they had a child from their class present or not. They usually attended the first and second days of the three day sessions. They stayed after the children had gone to discuss individual cases and to keep communicative channels between professions open.

The third day, after the class session was over, was devoted to a staff meeting summing up the cases, generating hypotheses, and working out specific plans for the future assistance to the child, the teacher and the schools.

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Following the diagnostic sessions, two members of the team went to the classroom for at least one more observation of the child after he had been seen in the diagnostic session and after he had been in his own classroom situation for a longer period of time. The interest generated in the suburban schools was great enough to warrant regular weekly meetings with teachers who had brought in children as well as the other teachers to discuss classroom behavior management, diagnostic clues, reasons for referral, etc.

Preliminary to the child's arrival at the diagnostic session, and even if he were not scheduled to come to the University but was showing difficulties, each child was tested by a senior psychologist or one of her three assistant psychologists who had all had experience in testing children of this age. Each psychologist had an observer-recorder to record the behavior of the child as well as his actual test performance on the Stanford Binet which was the standardized test used. The Binet was administered in two and sometimes three sessions, depending on the ability of the child to take the test or the need of the psychologist to establish better contact with the child.

Not only were the children tested, but family interviews were attempted. A questionnaire was drawn up by the psychiatrists and psycologists outlining the areas for investigation. The interest was in exploring familial attitudes and concerns rather than trying to get accurate family histories.

Finally, the professional team, the master teacher and her aide, the consultant teacher, two child psychiatrists, two psychologists, the speech consultant and a child psychiatry resident met in a series of intensive meetings to collate the data, draw up final reports and make specific recommendations. Two copies of the final reports of each child were sent to the appropriate agencies, one copy was kept on file at the University, and special reports were written for the teacher of each child to help her handle the child in the classroom setting.

DISCUSSION

This clinical survey raised more question than it had set out to answer. The major problem was shortness of time and limited population. In spite of this, the children who were followed were seen in a coordinated, sequential fashion by representatives of different disciplines, to report on behavior in many situations affording continuity, contrast and varying kinds of stress. Of particular interest was comparing the two social classes together operating in the same classroom under the same conditions.

Class differences in pathology were not as striking as the fact that there were so many girls. This has been baffling to the team. The incidents of pathology in boys is reportedly much higher in the general population but we saw as many girls as we did boys. We questioned if there was a social class influence in this phenomenon. The teachers and their training might have effected this sex choice. Young teachers seemed to be more lenient and understanding of boys' behavior than of girls'. Acting out among boys seemed to be acceptable to the teachers. They probably saw acting out, particularly in the inner city classes, as an adaptive function. We also felt that somehow the teams in the classroom were not getting at withdrawal symptons.

Also surprising was that not as many children were referred as expected because of aggressive acting out or anger. Aggressive acting out seem to appear lesser in the summer program. We could not detect any class differences on this score. We were also interested to find that all the children we saw were toilet-trained.

Even though the time was short, in looking at the covariation between situational and longitudinal maladjustment, marked changes could be seen in many of the children's behaviors over time. Some changed dramatically during the three day sessions, enabling us to define, categorize, and make more appropriate references than if we had only seen the child on a one-short basis.

In our experience in dealing with sub-communities, such as the schools, that have not been anxious to explore areas such as emotional disturbance, we have found that it is impossible to do decent research or even get into the schools unless you are able to promise and carry through on specific service to the children and to the teachers and the families that send children feel that some real good will come to them they will not cooperate. The visiting teachers were particularly anxious to have immediate help with problem children.

As this program continues, we will need more information than we were able to get in the process we had this summer for the benefit of the schools and our own research. Within the first month, all initial observations of classrooms and teachers in observing teams would be gathered. By the second month, family reports and psychologicals would be done. Then, in the third month, the special diagnostic class and the interviews could be done. It is most important that these children continue to be followed in the classroom as the year continues. We need more longitudinal information on these children, not only in their own development, but in general growth. We need to know a great deal more about the established values of systems of these children and their families. There is an inherent danger in providing these children with what we believe is an optimum program when this program is contrary to the values and expectations of the community involved. We can see the University playing an important role in setting up a strategy--a well thoughtout and carefully planned strategy--for getting this type of information on values and existing structures and then maneuvering for any type of appropriate, approximate social change which is considered feasible by the community as well as by the University and the research groups. We must consider the realistic setting in which the child moves and will move and adapt ourselves to these needs. There is an element of tragedy in setting up classes which are destined to guaranteed failure of the child in the setting to which he will return. On the conclusion of the third month, when all information is in on the children, an appropriate prediction should be made as to the development of this child and the possibilities of his being a school failure. Tests will have provided us not only an approximation of his personality development, his cognitive development, but also of his level of achievement. The predictions should focus on success and/or failure in school. This could then be checked out later in a longitudinal research study, which is now evolving.

Of great importance to the whole project is the question of feed-back to the community. It is most important that the agencies not only get the material as quickly as possible, with recommendations and findings on each child, but that they be responsible and prompt in getting special reports to the teachers and providing any follow-up discussion that might be necessary.

There should also be a follow-up on each child who was observed and picked up for some sign of maladaptive behavior but not serious enough to warrant referral to the diagnostic classroom. These children should all be carefully watched. It is suggested that a confidential report on the whole program go to the superintendents of schools so that they have some understanding not only of what we are doing, but of the magnitude and significance of emotional disturbance in preschool children in their areas. It is also important that SNAP have some idea of the degree and amount of incidents of emotional disturbance in their children so they can provide pressure for more specific help from the community action programs.

Our hypothesis that the attitude of school officials would be more cooperative and sustained in the middle class than in the lower class group was upheld. One of the major thrusts of this program was to help teachers understand emotional disturbance. It was of particular interest that the teachers in the suburb were more interested in the experiment came voluntarily more often, stayed longer, including the teachers who did not have children going through the diagnostic process, than the teachers in the inner city. The staff expressed more sympathetic rapport with the teachers in the suburb than they did with the teacher in the inner city. This was probably due to the fact that the city teachers were hired on a temporary basis, were not part of an established system, would be leaving the community at the end of the summer. Finally the whole general program in the public schools was in abeyance at the time of this program. Therefore, there was a certain hopelessness for all of us in approaching these city children, in trying to decide how effective, if effective at all, we could be with them, whereas the suburban system was well established and had an aura of performance. Besides the staff was excited by the newness and the creative approach of the University program.

Several suggestions were made as to how greater effectiveness could be achieved with the teachers in the over-all program. In the first place, it was suggested that the teachers should have written longer, more specific reports on each child they referred. These reports should have been followed up in detail by the psychiatrists and discussed with the teachers as to the degree of importance of their observations. Also suggested was that teachers go around to all classrooms to see how other teachers considered and dealt with children thought to be disturbed. The teachers should talk more with each other and with consultants. As a first step, every teacher could be invited in to observe the master teacher teaching a class of emotionally disturbed children. The second step could be to have a teacher choose a fellow teacher and the two of them go in compatible combinations to visit and attend other classes. The students in training at the University would be able to takeover the teacher's role in the classroom which would give the student experience and release the teacher for time to observe. Teachers' aides could also help in taking over the class so the teacher could be released. Specific seminars for the teachers could be used to discuss appropriate ways of getting help for their own children, how to observe, how to make choices on interventions, how to elicit active, immediate intervention from the administration. Primarily, the work with the teacher is one of communication: interdisciplinary communication, and communication with administrators as well as with children.

On the question of the initial observation by the psychiatrists, and consultants, it was felt that it was not necessary for teams to visit together, but that it would be more efficient and easier to have a person from each discipline go at his own time and convenience, but quickly when called by the teacher. There was a felt need, however, for trained observations of the classroom process as a whole unrelated to specific individuals. This probably could be done in the beginning weeks of the school so that each class could be described as to its general tenor and group dynamics, and the techniques and style of the teacher. We also felt that we spent too much time on the individual and neglected seeing them in their total setting. We also felt that it was important to keep a variety of observers moving through the schools: psychologists, psychiatrists, teachers, etc. to help the teacher understand and get to know the different types of professions who work with children, and keep communication between disciplines open.

Our hypothesis that structure could be imposed on clinical and observational procedures to facilitate the inferential processes was strengthened with our experimentation in the three day classroom setting. By putting the children through specific tasks, making uniform demands on all the children, by testing specific personality functions, such as frustration tolerance and delay of gratification, we were able to begin standardizing, for ourselves at least, clinical and observational procedures. We set up a series of events, trained observers and discussed among ourselves the areas of personality we were specifically investigating. In general, the first day was usually permissive, letting the child explore the rooms, sharing in games, sitting together for snacks. The second and third day more demands were made of the children. Tasks were assigned and pressure put on the child to complete them. However, since the shortness of time was so pressing, and because we could get most of the reactions we wanted during the two-day sessions, we would recommend that the diagnostic classroom be limited in the future to two days, and then spend the entire third day in group discussion with teachers, social workers and the professional staff to work out the time-consuming final reports.

It was also felt that many more children were seen and tested in the school situation than actually came into the diagnostic classroom. These children should have a thorough work-up and recommendation as the ones who came into the diagnostic classroom. As it is now these children are not being followed-up because of the lack of time. One idea that has been discussed was to have a diagnostic classroom in the community so that each school with its own indigenous problems could have the diagnostic classes in situ. However, this would present the problem of handling observers. There were often 15-20 professional observers in the observational booth at the University. No school in the inner city is equipped to accommodate this number. We did feel that the numbers and the exchange they provided were beneficial in diagnosing the children and fulfilling the aims of the program. There might be a possibility of having a large trailer which would go from school to school; but, then again, the observation facilities would be limited.

We were confirmed in our hypothesis that in certain situations, it was more efficacious to have professionally trained workers rather than idigenous, nontrained aides. One of the major areas of difficulty was in getting information on the families. In the suburbs where trained social workers collected data, the information came through rapidly and competently. All the areas were covered that we wanted to know about, although there is always the question of the validity of parents reports.

However, we were looking not so much for specific information on the child as the attitude of the parents toward the child and his development, and this did come through in responses to our open ended questions. In the inner city the situation was different. We had hoped originally to elicit the aid of the neighborhood aides, that are local residents, so that we could help the community recognize the general problem of emotional disturbance in children and give them some training in interviewing. But the SNAP administration felt this to be too ticklish a situation to handle at this time. The neighborhood workers were unwilling to ask for this kind of information because it was too personal. They feel that they are interfering and prying. Also the information was open to misinterpretation by untrained workers. Consequently, on the advice of the senior social worker at SNAP, we let him do all the interviews. However, his schedules could not be maintained so he had to assign one of his neighborhood aides to collect the data. This information was scant and tantalizing. For instance, on a question on a child's relationship to the mother, the answer was "yes". Recorded trauma to the child, such as death of a parent or major injury, would be briefly recorded with no dates or any clue as to how this had effected the general family constellation or the development of the child. We still feel that it would be a good idea to have the neighborhood aides learning and acting and supporting the program. We thought of having a trained social worker meet once a week with the neighborhood aides to help them learn how to collect data. SNAP discouraged taking forms in to be filled out by the families as this was too reminiscent of social welfare workers practices, which leads to resistance on the part of the parents. The aides, in general, know the families well and can give information without even asking specific questions of the family, as to the general tenor of the home, whether the mother's working, how many extended family are present, etc. This was the type of information we were looking for but which we are still trying to get. If we cannot get the aides to collect data and if we cannot train them ourselves, it would seem wise to have a professional social worker approach the problem of recording this information which is too important to have neglected or done haphazardly.

We also felt that the neighborhood aides could be used perhaps not to get all the information but at least to do a public relations job for us. So many of the parents had no idea of what was happening. Communications broke down very quickly between SNAP and parents. Many of the parents did not know that their children were coming to the University for diagnostic purposes and certainly did not know what we were doing at the University. One mother felt that we had given the children "needles" because they had been sick on their return from the University. This misconception could have been prevented if the neighborhood workers had been informing the parents about the program, making them see the usefulness of this program to their children. If we could have had a self-generating intercommunity program involving everyone in the community, we would have had greater success, not only in getting the diagnostic information but also in maintaining our follow-through study. We felt that the neighborhood aides should have been asked to the University. They should have been able to observe the sessions, and we should certainly have gone to their meetings and worked with them on their own specific problems. The main idea would be to get the community to work for itself, have the neighborhood workers give us gross information about the families, and be a public relations person for the program, and let the probing interviews and delicate subjects be approached by professionals not living in the immediate neighborhood.

The psychological testing raised several questions. Here it was felt that a professional, not a student in training, was needed to get the information from these young children. However, we would consider doctoral degree candidates with experience and training in this area as possible testers for the program. Although it was comparatively easy to test the children in the suburbs in one session, this was decidedly not so in the inner city. You needed two to three sessions with the child to get a valid sample of his performance. The child in the inner city initially resisted the meetings of the tester, but by the second or third day, he was quite willing to cooperate and his score was quite notably higher. The tester should also visit in the classroom for long observational periods to get to know the children and to look at cognitive function expressed in behavior in the classroom. All of this requires a spphisticated tester. If it is a student who is doing the testing, he should be closely supervised. There was some question whether the Binet was the appropriate test to use. It was suggested that perhaps a series of specialized tests and the standardizing of the observation and psychological approaches would be more effective in predicting emotional disturbance than the Binet alone. We would like to have tests of the relationship of the child with the teacher and with his peers and we would like to know more of his cognitive style and particularly any kind of tests, such as the Bender or equivilant that would reveal any central nervous system deficit or minimal brain disfunction.

We would like also to have noted changes in the classroom; that is, were there any differences in cognitive style as the child approached diverse tasks and added stress; what were the effects of different teaching styles and demands on different cognitive styles. The attitude of the child towards education and towards white people should have been noted to estimate of the child's level of aspiration and his ability to take risks. These are the data we felt would be helpful to describe children. Also included in this list of areas to explore were the child's handling of failure and his expression of aggression. Could the child request help from the peers and adults? Could he follow suggestions when they were given? Could he follow directions? Was there any relationship between social economic status on his ability to relate to peers and adults and follow directions? Could some of Piaget's and Brunner's tests be adopted to this population to see how cognitive hierachies were developing and how these hierachies were intergrated? Could special teaching techniques accelerate lagging areas of development? What types of materials interested the child? Did the child manifest a concrete or abstract approach to materials. Was he rigid or flexible in following the daily program? Was rigidity a form of perservation or obsessive behavior? How appealing was the child in general? How was the impulse control of the child? How as the child able to use play, for pleasure, mastery, learning of skills, people, things? Could he sustain what he started? What developmental tasks was he involved in? Could most of this material be gathered by trained observers-recorders watching free play?

On the subject of free play, we also wanted to see the sex role and identification processes, the choices of play material, whether they were male or female categories. In the classroom we would try to standardize the equipment and materials available, as well as the sequence of presentation of these materials so that we could have standardized means of analyzing the evoked behavior.

Again, this raises the issue of training. If the observers-recorders were undergraduates or people with little training in child development, cognitive process and clinical psychopathology, they are not able to observe with any kind of efficiency or report the significant material. Therefore, these observers-recorders should be first or second year master degree students or doctoral candidates who have been specifically trained as observer-recorders in a classroom for emotional disturbance.

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